were periods lasting several hours at a time when he was in semi-conscious condition. During this time he suffered from incontinence of urine and feces, which has since disappeared; no disturbance of speech.

After six months he was transferred to the Alms House. In Dec., 1907, he was readmitted to the City and County Hospital. He has been compelled to use a wheel chair since 1888. He complains of no pain except in the legs when occasionally they are attacked by convulsive movements. A number of years ago there was blurred vision, but now the eyesight is excellent. There is weakness in the lumbar muscles; hearing is good; no girdle sensation, bladder or rectal symptoms.

Physical examination: Fairly well nourished, expression alert, speech is slow, halting and in a monotone, i. e. fairly well marked scanning speech; pupils are small, equal and react sluggishly to light and accommodation. Nystagmus is not marked, eye ground normal, no involvement of the cranial nerves. Upper extremeties; there is a coarse, wavy tremor of both upper extremities at the rapidity of from 5 to 7 per second, the motion is lateral in the right hand and vertical in the left hand, especially in the index, middle and ring fingers. Muscular power fairly good. Lower extremities; there is a flaccid paralysis of both extremities, double drop foot, the only motion remaining is a slight power of extension of the leg on the thigh. Reflexes; both superficial and deep entirely abolished. Very little atrophy or vasomotor disturbance.

As to the clinical diagnosis in this case, I feel that we are justified in considering it an advanced case of multiple sclerosis. As a rule this disease begins between the tenth and thirty-first year, but no age is exempt, in the present instance the onset was at 37 years of age. Multiple sclerosis is not an inherited disease, neither is this; it has no relation to syphilis, nor is there any history of syphilis in this case. It usually follows cold, trauma or an acute infectious disease; in this case we have the well marked history of exposure. Multiple sclerosis is gradual in onset, usually beginning with numbness or weakness in the legs, spastic or cerebellar gait, with marked increased knee jerks and Babinski signs. The present case does not conform to these symptoms; it has gone beyond the stage of spasticity and is followed by the flaccid paralysis noted. The intention tremor is one of the characteristic symptoms of the disease, as is also the scanning speech. The tremor of the head somewhat similar to senile tremor is often noted in cases of multiple sclerosis, but this condition is not present here. Nystagmus is usually an early and persistent symptom, occurring in about 75 per cent of the cases; here the nystagmus is slight and can be practically disregarded. Temporary attacks of blindness are often noted in the early stages of this disease; in the present case attacks of blurred vision were present. Optic atrophy is frequently noted, occurring, according to Utthoff, in about 52 per cent. of the cases; the symptom is absent in this case. Paresthesias are frequently noted while anesthesia is never present, and similar conditions are noted in this case.

From the presence of the marked intention tremor, the slight nystagmus and the fairly characteristic scanning speech, and as we are able to exclude practically all of the other nervous diseases, I feel that we are justified in considering this clinically a case of multiple sclerosis.

Discussion.—H. C. McClenahan. Of course, in the discussion of the syndrone, that we generally call multiple sclerosis, much depends upon our pathological conception of the clinical picture we include in multiple sclerosis. Strümpel says that: "When we find a symptom complex, that we are unable to fit to any other disease of the central nervous system, it is a good plan to call it multiple sclerosis." I will state, however, that I have never accused multiple sclerosis of a flaccid paralysis of the lower limbs. It is new to me, and the man has apparently an Argyle Robinson pupil, at least the pupils seem sluggish to light.

The case Dr. Power has presented I saw at the City and County Hospital, and I thought at that time that the man was suffering from cerebro-spinal syphilis, and for the reason that the symptoms came on very abruptly, which is not so characteristic of multiple sclerosis, in our clinical conception of it. It is an insidious disease which comes on rather intermittently, instead of gradually or by sudden attacks. The pathological condition of multiple sclerosis of course cannot be diagnosed clinically, and whether this case is due to syphilis or not is the question. Owing to the abruptness of the onset and the great improvement, I think the case has many symptoms of cerebro-spinal syphilis.

Meeting of November 8, 1910.

The Etiological Significance of Persistent Affective States in Neurasthenia.

By G. V. HAMILTON, M. D., Montecito.

The current generalization that ascribes neurasthenia to mental and physical strain must at least be qualified with reference to the fact that a considerable percentage of cases give histories of having weathered without damage the major griefs, worries, responsibilities and activity-demands of life, only to have developed, after a considerable interval, and in the midst of an apparently comfortable situation, the characteristic symptoms of neurasthenia. It must be admitted, therefore, that if mental and physical strain are causes of this disorder, their etiological value often bears no consistent relation, in a given individual, to their intensity. Unless one be prepared to admit that the etiology of neurasthenia is wholly implicit in the make-up of its victims, it follows that progress in our understanding of the disorder demands, first of all, ever more careful analyses of the situations in which it arises.

The present communication is an attempt to point out an element which is common to a great diversity of concrete situations that appear in neurasthenic histories, and to assign to this element a value in terms of an interesting psycho-physical mechanism. The presentation of a typical case will serve to illustrate the intention of the discussion that follows:

Mrs. X, age 31 years, American, widow. Illustrator. Family and early personal history negative. The patient was a physically robust child, and presented no nervous traits that can be recalled. Until the onset of the present illness she habitually entered into the natural interests and activities of her life with great zest, and was quite free from marked fluctuations of mood, self-examination, dreaminess, seclusiveness, irritability, etc. Her ultimate breakdown was a source of much surprise to her friends, who had never thought of her as having "nerves."

She was married at 20, and a year later bore a child which now, at 10 years, presents a good history with respect to both mental and physical development. The patient's married life was happy and uneventful until its termination six years ago by the death of her husband. She bore his loss with great fortitude, and at once set about to support her child and herself, to which end she made a practical application of her artistic ability. The griefs, worries, disappointments and hard work incident to this period of her life brought no discoverable impairment.

At 30 she was earning a comfortable salary as an illustrator, directing her son's education with satisfaction to herself, and meeting the demands of a pleasant social life. Nevertheless, six months later she began to feel excessively tired during the morning hours, and to dread, at any time of the day, even the simplest demands for mental and physical exertion. Whenever she tried to read, her attention soon wandered, her eyes grew tired, and the back of her head "felt tight." Slight physical exertion brought an inordinate sense of fatigue. Her emotional reactions were too easily aroused, and she often found herself weeping from trivial causes. She had the usual neurasthenic parasthesias, headache, backache and "nervous indigestion."

Physical examination revealed a slight degree of anteroversion of the uterus. The patient stated that since the onset of her present nervous symptoms she had menstruated irregularly and too freely. The neurological examination was negative in its results. Association tests gave no evidence of pathogenic suppressions and substitutions.

At the first interview the patient was inclined to belittle her symptoms as such, but was much worried lest her domination by "imaginary ailments" would lead to insanity. She attributed her illness to over-exertion, an explanation which was suggested to her by the fact that she had spent an active winter in the pursuit of her profession and in a social way.

In view of the fact that this physically robust woman of 31 had passed through a far more strenuous and difficult period six years before, and had emerged from it unimpaired, it seemed incredible that she should now be thrown into a neurasthenia by meeting the pleasant and by no means excessive demands of her everyday life. After considerable probing a more satisfactory explanation was obtained.

It seems that for several months before the onset of her present illness she was courted by a man who developed a deep affection for her, and whose feeling she reciprocated. The suitor, who is at once very conscientious and very undecided in all serious matters, expressed a fear that he, a man of 50, had no right to marry a woman of 30. He admitted the sincerity of her present affection for him, but was much harassed by a fear that some day she would "wake up and regret her tie to an old man." The patient, on the other hand, was confident of her ability to ignore the age difference for all time, and was often momentarily successful in convincing him of this. But as his affection for her increased he grew more solicitous for her future welfare, and more painfully undecided. In the midst of this situation the patient became neurasthenic.

Her utter lack of knowledge of psychology as it is currently presented by Immanuelists, exponents of "new thought" and other amateurs in the field of applied psychology, rendered the patient an especially valuable subject for study. Her introspections were undistorted by semi-scientific preconceptions, hence she was able to give facts, rather than interpretations. On this basis I was able to obtain from her the following account of her modes of inner adjustment to the love affair.

The patient stated, in substance, that as long as art and her son were the primary values of her life she was able to obtain from these values the kind of satisfaction that met her deepest mental needs. When, however, art and her son were relegated to the rank of secondary values by the appearance of the man whom she loved and wanted to marry, she felt a great sense of emptiness whenever she pictured to herself a life without this man. As his indecision increased, and left her without prospect of marriage to look forward to as a certainty, she could conceive of no alternate source of satisfaction. There followed a continuously present feeling of emptiness and of inner tension. She assured me that if her suitor were to die or to marry another woman she could adjust herself to either contingency as to one of the unhelpable things of life; she ascribed her feeling of tension to her ever-present state of unsatisfaction.

We have in this record a sequence of events from initial environmental factors to terminal symptom-reactions which can be isolated in form from a surprisingly large percentage of neurasthenic histories. Our problem, then, requres us to formulate the successive members of the sequence and to search for such causal relations as may obtain among these various members. This calls for an examination of (1) that primitive tendency of human mental life which impels the individual to seek for a definition of values to be pursued; (2) the nature of the affective reactions that are traceable to thwartings of this instinct; and (3) the phychophysical consequences of such reactions.

(1) As Judd (a) has pointed out, the whole scheme of mental evolution revolves about the tendency of the human mind to conceive ever higher values, which it can obtain only by effecting changes in its environment. Now, sexual-romantic values are the fairly constant sources of adolescent satisfaction, hence the information required for our present purposes can be most easily obtained by a brief interrogation of this period of individual development. The affective life of the average youth clearly shows that his greatest mental need is met by the satisfaction that he derives from activities which promise to advance him toward a conceived sexual-romantic goal. In the beginning it is sufficient to behave without awkwardness in the presence of young girls; later, the youth requires the tangible evidence of a love affair. Now let the limitations of his environment, or of his own make-up as he conceives it, thwart his efforts to obtain current sexual-romantic satisfactions, and there follows an affective state which is as clean-cut and as typical in its relation of effect to cause as can be found anywhere else in nature. The thwarted youth finds all at once that life is an empty, painfully unhappy and burdensome affair. He is dominated by a restless, unsatisfied feeling, which robs him of his ability to enjoy his usual secondary values. Along with this there is an inner tension which, though difficult to describe, is a most real and self-assertive subjective experience. Fortunately, some kind of readiustment usually follows, and the thwarted value-defining, value-pursuing instinct asserts itself anew in the form of satisfying activities.

Contrary to the implications of Freud's doctrines, my experience leads me to believe that as the individual passes from adolescence to maturity he is apt to carry with him as determinants of his further mental life merely habits of reacting to his fundamental needs: indeed, I prefer to go even further than Adolf Meyer (b) has gone in ascribing pathogenic value to these habit-reactions: they, I believe, and not the memories of the sexual experiences that we have suppressed, are usually the specific causes of our mental difficulties. As the central value of an individual's life shifts from the sexual-romantic to some other basis, his spontaneous activities are manifested in other directions than the sexual, and an examination of these activities must be made before we can safely decide what are the sources to which he looks for his deeper satisfaction. In women it is often the gregarious instinct that plays the determining role, so that removal from a familiar neighborhood to one where pleasant social contacts with other women are unobtainable may lead to the subjective experiences described above, viz.,

restlessness, emptiness, inner tension. In another type of individual the dominant instinct of adult life finds expression in a vital need of activities which shall be relevant to a conceived achievement-goal. The man who does constructive work along any lines is usually held to his task by an ever-recurring hunger for the satisfaction that he can obtain only from his special modes of activity. It is beyond the scope of the present communication to enumerate the kinds of values that may become the central needs of human mental life after the sexual-romantic instinct loses its dominant force. The point that is essential to our present purpose is this: it is intrinsically a part of our mental life to construct a group of closely related interests or values from which alone the vital satisfactions can be obtained.

(2) What is the nature of the affective states that occur in reaction to situations which thwart the individual's efforts to draw upon these values for satisfaction? According to Wundt's (c) famous tridimensional theory of feelings, these components of consciousness are possessed of three pairs of opposite qualities or attributes, viz., pleasantness and its opposite (unlust), excitement and depression, tension and relaxation. Thus the feeling that I experience in reaction to meeting a colleague to whom I wish to unfold my conceptions of neurasthenia is possessed (according to Wundt's theory) of the following qualities: pleasantness, excitement and a moderate degree of tension. Or, when I return to my home after a strenuous day in town and find a comfortable chair from which to observe the deepening purple of the mountains, my state of feeling has the qualities of pleasantness, mild depression, and relaxation.

A closer examination of the tension-relaxation pair of opposites reveals the fact that, as Titchener (d) suggests, they are not **qualities of feeling,** but **independent sensations.** For example, the pleasurableness of my feeling when I meet my colleague is a totally different kind of event in my consciousness from that informative and purely sensory conscious event which makes me aware of an organic consequence (the tension-sensation) of the pleasurable, exciting feeling. Everyday life affords numerous examples of the psychophysical sequence which has for its members (1) a presentation or representation, (2) a state of feeling, (3) organic consequences of this feeling, (4) sensations which inform the individual of the organic event. Another example will serve to make this clear in its intention.

A surgeon who has just completed an operation falls to wondering if the stringy mass that he severed a moment ago could have been a ureter. There follows in the surgeon's consciousness a highly disagreeable feeling, then something physical happens which produces an uncomfortable sensation referable to the precordial region.

Another characteristic of affective states which is highly important for our understanding of neurasthenia is their tendency to persist in the background of consciousness long after the idea that gave rise to them has ceased to be central in the field of attention. Every physician knows that he may carry home with him a vague, uncomfortable feeling which may not be at all appropriate to what now occupies his thoughts. A moment's reflection over the events of the day enables him to recall that at some time during his office hours he blundered in his efforts to reassure a nervous patient. The patient perceived and reacted to the blunder, and the physician thought for a moment, "I am stupid and lacking in tact—my practice will fall away from me if I am not more on the alert!" etc. But the idea had to be dismissed before it could be squared and made acceptable, in one way or another, to the main body of his consciousness.

Now, it is quite possible that in such cases there is at work the psychological mechanism to which Freud ascribes the repressions, displacements, substitutions and independent activities of emotions attendant on ideas which are inacceptable to consciousness as we know it in terms of personal experience. Whoever has read and accepted Freud's "Psychopathology of Everyday Life" (e) would doubtless place this interpretation on the persistence of vaguely unpleasant affective states which so often appear incongruous with the central interests of the moment; and this consideration may justify Waterman's (f) assumption that neurasthenic mental states are traceable to true dissociation. But I believe that wherever it is possible to make psychological analyses in terms of mental life as we know it directly, it is well to avoid any appeal to an hypothetically constructed "unconscious" or "co-conscious" mechanism. And in the present instance it seems to me to be sufficient to state the facts of affective persistence (as they are found in normal life and in neurasthenia), in terms of known mental reactive tendencies. I would therefore subject these facts to the following formulation:

An unsatisfactory situation which does not lead to definite and acceptable readjustments on the part of the individual into whose experience it enters is apt to produce an affective reaction which persists in consciousness long after awareness of the situation itself has been entirely replaced by new presentations.

That in the case of neurasthenia there is no necessity of going further than this in the assumption of dissociation is warranted, I believe, by facts which are accessible to any psychopathologist who has time and patience at his disposal. I have found that once my neurasthenics are convinced of the value of absolute frankness in their attitude toward themselves, their families and their physician, they are able to recall, without resorting to artificial aids (e. g., dream analyses, free association, hypnoidal states), the specific experiences to which their dominant affective states are attributable. Thus, a clergyman whose neurasthenia was accompanied by the usual dominant affective tone of "emptiness," restlessness and unsatisfied longing, confessed to me that this affective state dated from the "first beginnings of a conviction—which he had never dared to face—that the Christ whom he was required to defend as a member of the Holy Trinity was, after all, only one of the world's great men." He feared that if he were to attempt to square himself with this vaguely formulated conviction he would force himself out of the only profession in which he could gain a livelihood.

Another neurasthenic, a rather garrulous and tiresome woman of 55, ultimately confessed to me that she had long known, "in the back of her head," that the daughter with whom she makes her home, and on whom she is dependent for her only intimate social contacts, is bored whenever she, the patient, talks. The kindliness of the daughter in all other matters, and her well-meant efforts to conceal the fact that her mother does bore her, made it difficult for the patient to face the issue frankly. "My conversation bores my daughter," was an idea which she never allowed to become sufficiently focal in consciousness to permit healthy readjustments.

Still another neurasthenic, who is exceedingly loyal to his wife, even in the privacy of his own thoughts, admitted that the intensity of his ever-present uncomfortable affective state varied directly with the degree to which his wife gave expression

to her habitual tendency to contradict him in all small matters. For example, they would draw up before the fire to spend a comfortable evening together, and he would say, "I enjoyed my supper very much—especially the peas." To this the wife would respond, from sheer habit, and not unkindly, "Dear me! Do you think they were good? They were altogether too hard; you must tell the grocer to be more careful when he fills our order." An accentuation of his uneasy affective state would immediately follow, and long after his attention had been diverted to other interests he would be conscious of the increase in his "feeling of emptiness."

(3) The final step in our analysis of the sequence that begins with the type of situation in which neurasthenia so frequently develops, and ends with the full manifestation of this disorder, requires an examination of the inner tension to which I have referred as an organic consequence of certain affective states.

It is my practice to ask of every neurasthenic, "Do you feel easy and relaxed and comfortable when you sit down, with your own approval, to read the evening paper?" This question usually elicits a negative response, and the patient is apt to add that, on the contrary, he is never wholly free from an inner tension which makes relaxation impossible. The most illuminating description of this inner tension that I have yet received from a patient is as follows: "It is like, in quality, the tension that accompanies anger; but much less intense in degree."

If we consider for a moment the physical after-effects of anger, we shall discover in these a most suggestive resemblance to the cardinal symptoms of neurasthenia: both the individual whose anger has just faded, and the neurasthenic, experience an uncomfortable sense of exhaustion, inability to concentrate the attention, a feeling of psychomotor inadequacy, inner tension and, not infrequently, a disturbance of the total organic sensation referable to the head and neck regions. One need grant only two assumptions—both of which are justified, I believe, by facts of introspection—in order to arrive at a definite formulation of a highly important factor concerned in the production of neurasthenia. These assumptions are, (1) that the tension accompanying persistent affective states differs from emotional tension only in degree of intensity and in duration, and (2) that the tension of these persistent affective states may produce, in spite of their low degree of intensity, the same types of physiological disturbance that are traceable to emotional tension.

The usual rapid discharge of an emotion permits a return to the normal within a relatively limited time, whilst in neurasthenia, continuation of the secondary disturbances is insured by a tendency of the tension-producing affective states to persist. The final formulation of the psychological sequence under discussion is, therefore, as follows:

(1) A situation or series of situations which, though unfavorable to the primitive mental needs of the patient, do not lead to adequate and satisfactory readjustments.

(2) A consequent persistence of the affective state thus conditioned.

(3) Organic consequences of the persistent affective state (which are made known to consciousness in terms of tension-sensation).

(4) Secondary effects of these "organic consequences," which effects constitute the cardinal symptoms of neurasthenia, viz.: marked sense of fatigue, subjective psychomotor inadequacy, and disturbances of voluntary attention.

To what extent the variable symptoms of neurasthenia may be due to the chain of psychophysical causes just enumerated is a matter for clinical and laboratory research; the present communication is offered merely as a suggestion for further study along familiar lines, and does not pretend to account for more than a certain percentage of the cases that are currently diagnosed "Neurasthenia."

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Discussion. H. C. McClenahan: Dr. Hamilton has given us a very interesting analysis of cases of so-called sexual neurasthenia. The most interesting point that has always impressed me in these cases is the question as to whether these various morbid psychological manifestations are a cause or a result of the condition. The treatment by suggestion of course, is responsible for many apparent curative results, and this, regardless of the method employed. Even physical methods are apparently not a factor in the premanency of the cure. These cases get cured but the trouble is they won't stay cured.

Philip King Brown: This subject admits of a wide field for discussion. In these cases I always make it a point in reasoning with the patients as to the necessity of this analysis of cases that Dr. Hamilton has made so plain to us, to illustrate by a few examples and so bring it home to the mind of the laity. A person waking in the night hears a strange sound and immediately thinks of burglars. There is a reaction of this sound out of proportion to the actual sound, and the state of mind existing at the time gives it entirely undue importance. There is fear, anxiety, confusion or alarm, or a mixture of all these steadily growing worse as the sound continues. It takes very little reasoning sometimes if it can be applied opportunely to straighten that thing out, although just as long as the person thinks there is a burglar in the house, the reaction continues. However, suppose the continuance of that sound suggests to the person that it is not the kind of sound made by a burglar in walking stealthily or endeavoring to pick a lock or to bore a hole. Finally, as the mind wanders over possibilities, suppose the thought flashes across it that the sound is caused merely by the flapping of a curtain in the wind or water dropping into a sink. Immediately the reasonableness of the thing and its full explanation of the phenomenon, quiet fear and the person is at rest. Such a thing suggests to us both the way disturbances are brought about and the way the cure is effected. A reasonable attitude of the person toward the thing which exists without a change in the existence of that thing, brings about the cure. It is not the altered conditions but the altered point of view of the person.

Another illustration is that of a horse that shies. If the horse is put into the hands of unskilled persons he will shy at an engine or an automobile and he will soon pass into the stage of not only shying at anything that is around but of looking for something to shy at. Put the horse into the hands of someone who understands the animal and he knows just what to do. He begins by taking the horse away and giving him a rest. He then takes that perfectly useless animal and restrains its nervous system. The trainer, taking advantage of his knowledge of horses and their habits, and the confidence that he inspires in the horse, so carefully carries

out his system of re-education that the horse will finally walk up to the automobile and will not shy at anything. That is the principle that underlies the cure of these cases. We cannot treat nervous cases, in view of the enormous insight into the whole situation that psychology and psycho-analysis have brought out, without an appreciation of the work contributed to our present knowledge of functional diseases by Freud, Janet, Morton Prince, DuBois and Sidis.

Clarence Quinan: I believe that suggestive treatment in these nervous states is a very dangerous experiment,—decidedly one that we should avoid. I would like to ask Dr. Hamilton whether his patient was subject to insomnia; indeed I am curious to know how frequently he has noted this symptom among his psychasthenic patients.

Langley Porter: I would like to hear from Dr. Hamilton more about Freud's statements regarding hysterical suppressions and displacements. As Dr. Arnold has just said, we are all more or less neurasthenic, but there is a definite prophylaxis for neurasthenia and it lies in the providing of proper surroundings and training for our children. Nearly all cases of neurasthenia can be traced to some displacement which took place during childhood; children cannot be treated as adults and come to adult life with a perfectly normal reaction between their nervous system and their environment.

Gilbert V. Hamilton, Santa Barbara: I beg to correct the impression that I have been discussing sexual neurasthenia; on the contrary I have sought to show that the persistent unsatisfied feelings of this disorder may not be at all related to the sexual life in some cases. The assumption that subconscious or unconscious mechanisms may play a role in these cases is based upon a purely hypothetical conception, it must be remembered, since direct, uninterpreted experience discloses only one general kind of consciousness—that which occurs to us when we are wide awake, or drunk, or dreaming, etc. It cannot be denied, of course, that many of our experiences cannot be brought into memory by the ordinary processes of recall; but that these may have the etiological value ascribed to them by Freud has not yet been fully established, I believe. My experience with normal subjects whom I have subjected to psycho-analysis has shown me that in every person it is possible to rekindle memories which have long since passed beyond voluntary recall, thus establishing their associative connections with consciousness. There can be no doubt that Freud has yet to prove that his method enables us to ascribe casual relations to that which is, in a psychological sense, associative continuity from present symptom to ancient experience. In adducing the "proof of the pudding" argument we ignore the possibility that to restore a suppressed sexual experience to the memory of an hysterical patient, may have only the same kind of therapeutic value that a bone from the little finger of a saint has for the devout Catholic.

Eye, Ear, Nose and Throat Section, November 22. Presentation of a Case.

By KASPAR PISCHEL, M. D., San Francisco.

Dr. Pischel showed a case of symblepharon in which he used the foreskin to cover the socket for an artificial eye. The patient had lost his left eye 18 years ago, being burned by molten metal. Both eyelids were grown together entirely. A fine opening through which much pus was discharged showed that some mucous membrane was still left. After severing the lids and the removal of the small, shrunken eyeball a circumcision was made and part of the foreskin put in the wound, pressed firmly into it by a paraffin ball after the borders had been anchored to the lids. The operation had been performed ten days ago and the appearance of the skin justified the hope that it would remain alive.

Discussion. M. W. Frederick: If Dr. Pischel is successful in this undertaking he certainly has achieved something worth achieving. This is one of the most difficult things in eye surgery; I know for I have just been through it myself. A boy was brought to me five or six months ago, whose eye had been injured with hot water; a general surgeon twice tried to make a socket. I cleared out the socket, took the skin graft from the back of the arm and tied the graft to a ball of gauze saturated with liquid vaseline. The ball was inserted into the socket and allowed to remain there four days. There was plenty of skin graft and the result was a very good one. Although I made a very large cavity and cleaned out a lot of tissue, at the end of three weeks the cavity had closed up so tightly that there was absolutely no question of putting in a glass eye. I proposed a further operation, intending to try a Wolf graft, but the parents did not want to take the chance as he had been under the anesthetic three times. I must say that this idea of Dr. Pischel is quite new to me.

SOCIETY REPORTS

ALAMEDA COUNTY.

The Alameda County Medical Society held its regular meeting at 127 Telegraph avenue, October 18, 1910, at 8:30 p. m.

The topic of the evening was Diseases of Childhood.

Program arranged by Dr. H. N. Rowell.

Report of a case of hydatidaform mole with specimens by Dr. W. S. Porter, was omitted, Dr. Porter being absent.

The following program with the exception of Dr. Dudley Smith's paper, was given:

I. Acute Articular Rheumatism in Childhood. By Dr. W. O. Smith.

II. Intestinal Hemorrhages in the Newborn with Demonstrations. By Dr. Daniel Crosby.

III. Report of a case of Congenital Megalcolon with demonstrations. By Dr. Dudley Smith.

IV. Acute Poliomyelites. By Dr. H. N. Rowell.

These subjects proved exceedingly interesting and brought out a full discussion. The opinion that anterior, or better, infectious poliomyelites should be made a reportable and quarantinable disease was unanimous, and many suggestions as how best to bring this about were made and discussed. A motion prevailed that a committee be appointed to confer with the Board of Supervisors with regard to making Infectious Poliomyelites a reportable disease.

The following resolution, introduced by Dr. C. A. Buckel, was adopted:

"Owing to the fact that no suitable provision is made for the development and education of defective children in the public schools of California, the Alameda County Medical Society respectfully asks the authorities of the State University to include practical training in pathological psychology in the Department of Pedagogy. It is the want of scientifically trained teachers who have a love for teaching children that prevents the segregation of defective children into special classes where the necessary appliances can be used for their highest development.

"Therefore, we send this petition for consideration and hope for speedy and favorable action."

P. S. NUSBAUMER,
Secretary.